Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 8-2-01.
   b. The request was received on 7-29-02.

## II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. UB-92
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92
   c. EOBs
   d. Methodology
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. No Carrier sign sheet was noted in the dispute packet. However, the Carrier's responses are noted in the dispute packet as Exhibit II.

## III. PARTIES' POSITIONS

1. Requestor: No position statement was noted in the dispute packet.

2. Respondent: Letter dated 9-3-02.
   "In conclusion, Carrier's rate of reimbursement in this case not only meets but exceeds the Act's criteria for payment in all respects. Provider has the burden of proof in this case. The Provider has simply not met its burden of proof under 133.305(e)(1)(F) to establish that its billed charges of $5,269.13 meet the statutory standards under the Act. On the contrary, this amount is grossly excessive as established by the Commission's inpatient surgical per diem rate; the Medicare rate; the payment rate established by the workers' compensation authorities in Nevada, Massachusetts, Pennsylvania, and Mississippi; the anticipated rate under the ASC fee guideline being drafted by the Commission; and finally, the rate determined by SOAH to be fair and reasonable in prior

ASC disputes. For these reasons, Provider has not met its burden of proof to establish that its charges of $5,269.13 comply with the Act's statutory standards for reimbursement. Therefore, it is not entitled to additional reimbursement."

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-2-01.

2. The carrier denied the billed services reflected on the EOB as, "F – The 'Amount Allowed' may reflect an adjustment due to repricing to applicable state fee schedules and/or exclusions of patient convenience items."

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,209.13 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid in the amount of $994.54.

5. The amount in dispute according to the Table of Disputed Services is $4,159.59.

6. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

## V. RATIONALE

Medical Review Division's rationale:

The UB-92 indicates the services were performed at an outpatient/ambulatory surgical center. Pursuant to Rule 133.307 (g) (3) (D), the requestor must provide "…documentation that discusses, demonstrates and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement …".

The carrier, according to their denial on the EOB, asserts that they have reduced the billed amount pursuant to "…an adjustment due to repricing to applicable state fee schedules and/or exclusions of patient convenience items." The services rendered were billed appropriately. The carrier has raised the issue of fair and reasonable in their position statement, however, "M" or fair and reasonable was not noted as a denial prior to the filing of the dispute. TWCC Rule 133.307 (j) (2) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an initial request. Any new denial reasons or defenses raised shall not be considered in the review."

Likewise, Commission Rule 133.304 (c) also requires, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and

manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." The carrier has raised an additional denial issue after the date of filing of dispute and has failed to expand on or support the denial code reflected on the EOB dated 9-5-01.

Therefore reimbursement is recommended in the amount of **$4,159.59**.

The above Findings and Decision are hereby issued this 31st day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll

## VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$4,159.59** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 31st day of March 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

CO/ll